CHAPTER 59

(HB 650)

AN ACT relating to health benefit plans.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

SECTION 1. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Notwithstanding any other provision of law to the contrary, an insurer that issues or renews a health benefit plan on or after January 1, 2005, and before December 31, 2007, shall not be required to include any additional state mandated benefit beyond those statutory requirements in effect for health benefits plans on the effective date of this section.

(2) An insurer issuing or renewing a health benefit plan may elect to expand coverage on any group, individual, or association health benefit plan.

(3) An insurer issuing or renewing a health benefit plan shall not suspend, limit, or modify any state mandated benefit in effect on the effective date of this section.

(4) An insurer issuing or renewing a health benefit plan shall not suspend, limit, or modify any federal mandated benefit in effect on the effective date of this section or any federal mandated benefit that becomes effective after the effective date of this section.

(5) Nothing in this section shall affect the fiscal impact statement required by KRS 6.948 to be attached to any legislation mandating health insurance benefits.

SECTION 2. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

An insurer that offers a health benefit plan that is not a managed care plan but provides financial incentives for a covered person to access a network of providers shall:

(1) Notify the covered person, in writing, of the availability of a printed document, in a manner consistent with KRS 304.14-420 to 304.14-450, containing the following information at the time of enrollment and upon request:

(a) A current directory of the in-network providers from which the covered person may access covered services at a financially beneficial rate. The directory shall, at a minimum, provide the name, type of provider, professional office address, telephone number, and specialty designations of the network provider, if any; and

(b) In addition to making the information available in a printed document, an insurer may also make the information available in an accessible electronic format;

(2) Assure that contracts with the providers in the network contain a hold harmless agreement under which the covered person will not be balanced billed by the in-network provider except for deductibles, co-pays, coinsurance amounts, and noncovered benefits;

(3) File with the department a copy of the directory required under subsection (1) of this section;

(4) Have a process for the selection of health care providers who will be on the insurer's list of participating providers, with written policies and procedures for review and approval used by the insurer. The insurer shall establish minimum professional requirements for

participating health care providers. An insurer may not discriminate against a provider solely on the basis of the provider's license by the state;

(5) Not contract with a health care provider to limit the provider's disclosure to a covered person, or to another person on behalf of a covered person, of any information relating to the covered person's medical condition or treatment options;

(6) Not penalize a health care provider, or terminate a health care provider's contract with the insurer, because the provider discusses medically necessary or appropriate care with a covered person or another person on behalf of a covered person. The health care provider may:

(a) Not be prohibited by the insurer from discussing all treatment options with the covered person; and

(b) Disclose to the covered person or to another person on behalf of a covered person other information determined by the health care provider to be in the best interests of the covered person;

(7) Include in any agreements it enters into with providers for the provision of health care services a clause stating that, upon request, the insurer shall provide the provider with specific fees for requested codes applicable to the compensation that the provider will receive under the contract with the insurer within thirty (30) days of the date of such request;

(8) Establish a policy governing the removal of and withdrawal by health care providers from the provider network that includes the following:

(a) The insurer shall inform a participating health care provider of the insurer's removal and withdrawal policy at the time the insurer contracts with the health care provider to participate in the provider network, and when changed thereafter;

(b) If a participating health care provider's participation will be terminated or withdrawn prior to the date of the termination of the contract as a result of a professional review action, the insurer and participating health care provider shall comply with the standards in 42 U.S.C. sec. 11112; and

(c) If the insurer finds that a health care provider represents an imminent danger to an individual patient or to the public health, safety, or welfare, the medical director shall promptly notify the appropriate professional state licensing board; and

(9) Meet all requirements provided under KRS 304.17A-600 to 304.17A-633 and KRS 304.17A-700 to 304.17A-730.

Section 3. KRS 304.17A-095 is amended to read as follows:

(1) (a) Notwithstanding any other provisions of this chapter to the contrary, each insurer that issues, delivers, or renews any health benefit plan to any market segment other than a large group shall, before use thereof, file with the commissioner its rates, fees, dues, and other charges paid by insureds, members, enrollees, or subscribers. The insurer shall also submit a copy of the filing to the Attorney General and shall comply with the provisions of this section. The insurer shall adhere to its rates, fees, dues, and other charges as filed with the commissioner. The insurer shall submit a new filing to reflect any material change to the previously filed and approved rate filing. For all other changes, the insurer shall submit an amendment to a previously approved rate filing.

(b) Notwithstanding any other provisions of this chapter to the contrary, each insurer that issues, delivers, or renews any health benefit plan to a large group as defined in KRS 304.17A-005 shall file the rating methodology with the commissioner and shall submit a copy of the filing to the Attorney General.

(2) (a) A rate filing under this section may be used by the insurer on and after the date of filing with the commissioner prior to approval by the commissioner. A rate filing shall be approved or disapproved by the commissioner within sixty (60) days after the date of filing. Should sixty (60) days expire after the commissioner receives the filing before approval or disapproval of the filing, the filing shall be deemed approved.

(b) In the circumstances of a filing that has been deemed approved or has been disapproved under paragraph (a) of this subsection, the commissioner shall have the authority to order a retroactive reduction of rates to a reasonable rate if ***the commissioner subsequently determines that the filing contained misrepresentations or was based on fraudulent information, and if*** after applying the factors in subsection (3) of this section the commissioner determines that the rates were unreasonable. If the commissioner seeks to order a retroactive reduction of rates and more than one (1) year has passed since the date of the filing, the commissioner shall consider the reasonableness of the rate over the entire period during which the filing has been in effect.

(3) In approving or disapproving a filing under this section, the commissioner shall consider:

(a) Whether the benefits provided are reasonable in relation to the premium or fee charged;

(b) Whether the fees paid to providers for the covered services are reasonable in relation to the premium or fee charged;

(c) Previous premium rates or fees for the policies or contracts to which the filing applies;

(d) The effect of the rate or rate increase on policyholders, enrollees, and subscribers;

(e) Whether the rates, fees, dues, or other charges are excessive, inadequate, or unfairly discriminatory; and

(f) The effect on the rates of any assessment made under KRS 304.17B-021; and

(g) Other factors as deemed relevant by the commissioner.

(4) The rates for each policyholder shall be guaranteed for twelve (12) months at the rate in effect on the date of issue or date of renewal.

(5) At any time the commissioner, after a public hearing for which at least thirty (30) days' notice has been given, may withdraw approval of rates or fees previously approved under this section and may order an appropriate refund or future premium credit to policyholders, enrollees, and subscribers if the commissioner determines that the rates or fees previously approved are in violation of this chapter.

(6) Notwithstanding subsection (2) of this section, premium rates may be used upon filing with the department of a policy form not previously used if the filing is accompanied by the policy form filing and a minimum loss ratio guarantee. Insurers may use the filing procedure specified in this subsection only if the affected policy forms disclose the benefit of a minimum loss ratio guarantee. An insurer may not elect to use the filing procedure in this subsection for a policy form that does not contain the minimum loss ratio guarantee.

Insurers may not amend policy forms to provide for a minimum loss ratio guarantee. If an insurer elects to use the filing procedure in this subsection for a policy form or forms, the insurer shall not use a filing of premium rates that does not provide a minimum loss ratio guarantee for that policy form or forms.

(a) The minimum loss ratio shall be in writing and shall contain at least the following:

1. An actuarial memorandum specifying the expected loss ratio that complies with the standards as set forth in this subsection;

2. A statement certifying that all rates, fees, dues, and other charges are not excessive, inadequate, or unfairly discriminatory;

3. Detailed experience information concerning the policy forms;

4. A step-by-step description of the process used to develop the experience loss ratio, including demonstration with supporting data;

5. A guarantee of a specific lifetime minimum loss ratio, that shall be greater than or equal to the following, taking into consideration adjustments for duration as set forth in administrative regulations promulgated by the commissioner:

   a. Seventy percent (70%) for policies issued to individuals or for certificates issued to members of an association that does not offer coverage to small employers;

   b. Seventy percent (70%) for policies issued to small groups of two (2) to ten (10) employees or for certificates issued to members of an association that offers coverage to small employers; and

   c. Seventy-five percent (75%) for policies issued to small groups of eleven (11) to fifty (50) employees;

6. A guarantee that the actual Kentucky loss ratio for the calendar year in which the new rates take effect, and for each year thereafter until new rates are filed, will meet or exceed the minimum loss ratio standards referred to in subparagraph 5. of this paragraph, adjusted for duration;

7. A guarantee that the actual Kentucky lifetime loss ratio shall meet or exceed the minimum loss ratio standards referred to in subparagraph 5. of this paragraph; and

8. If the annual earned premium volume in Kentucky under the particular policy form is less than two million five hundred thousand dollars ($2,500,000), the minimum loss ratio guarantee shall be based partially on the Kentucky earned premium and other credibility factors as specified by the commissioner.

(b) The actual Kentucky minimum loss ratio results for each year at issue shall be independently audited at the insurer's expense and the audit shall be filed with the commissioner not later than one hundred twenty (120) days after the end of the year at issue. The audit shall demonstrate the calculation of the actual Kentucky loss ratio in a manner prescribed as set forth in administrative regulations promulgated by the commissioner.

(c) The insurer shall refund premiums in the amount necessary to bring the actual loss ratio up to the guaranteed minimum loss ratio.

(d) A Kentucky policyholder affected by the guaranteed minimum loss ratio shall receive a portion of the premium refund relative to the premium paid by the policyholder. The refund shall be made to all Kentucky policyholders insured under the applicable policy form during the year at issue if the refund would equal ten dollars ($10) or more per policy. The refund shall include statutory interest from July 1 of the year at issue until the date of payment. Payment shall be made not later than one hundred eighty (180) days after the end of the year at issue.

(e) Premium refunds of less than ten dollars ($10) per insured shall be aggregated by the insurer and paid to the Kentucky State Treasury.

(f) None of the provisions of subsections (2) and (3) of this section shall apply if premium rates are filed with the department and accompanied by a minimum loss ratio guarantee that meets the requirements of this subsection. Such filings shall be deemed approved. Each insurer paying a risk assessment under KRS 304.17B-021 may include the amount of the assessment in establishing premium rates filed with the commissioner under this section. The insurer shall identify any assessment allocated.

(g) The policy form filing of an insurer using the filing procedure with a minimum loss ratio guarantee will disclose to the enrollee, member, or subscriber as prescribed by the commissioner an explanation of the lifetime loss ratio guarantee, and the actual loss ratio, and any adjustments for duration.

(h) The insurer who elects to use the filing procedure with a minimum loss ratio guarantee shall notify all policyholders of the refund calculation, the result of the refund calculation, the percent of premium on an aggregate basis to be refunded if any, any amount of the refund attributed to the payment of interests, and an explanation of amounts less than ten dollars ($10).

(7) The commissioner may by administrative regulation prescribe any additional information related to rates, fees, dues, and other charges as they relate to the factors set out in subsection (3) of this section that he or she deems necessary and relevant to be included in the filings and the form of the filings required by this section. When determining a loss ratio for the purposes of loss ratio guarantee, the insurer shall divide the total of the claims incurred, plus preferred provider organization expenses, case management and utilization review expenses, plus reinsurance premiums less reinsurance recoveries by the premiums earned less state and local premium taxes less other assessments. For purposes of determining the loss ratio for any loss ratio guarantee pursuant to this section, the commissioner may examine the insurer’s expenses for preferred provider organization, case management, utilization review, and reinsurance used by the insurer in calculating the loss ratio guarantee for reasonableness. Only those expenses found to be reasonable by the commissioner may be used by the insurer for determining the loss ratio for purposes of any loss ratio guarantee.

(8) (a) The commissioner shall hold a hearing upon written request by the Attorney General. The written request shall be based upon one (1) or more of the reasons set out in subsection (3) of this section and shall state the applicable reasons.

(b) An insurer may request a hearing, pursuant to KRS 304.2-310, with regard to any action taken by the commissioner under this section as to the disapproval of rates or an order of a retroactive reduction of rates.

(c) The hearing shall be a public hearing conducted in accordance with KRS 304.2-310.

Section 4. KRS 304.17A-250 is amended to read as follows:

(1) The commissioner shall, by administrative regulations promulgated under KRS Chapter 13A, define one (1) standard health benefit plan***. After July 15, 2004, insurers may offer the standard health benefit plan in the individual or small group markets***~~[that shall provide health insurance coverage in the individual and small group markets after June 30, 1998. As a condition of doing business in the small group market in the Commonwealth, the health insurer shall offer the standard health benefit plan, but the extent to which the standard health benefit plan shall be offered on a guaranteed issue basis shall only be as provided in KRS 304.17A-200. As a condition of doing business in the individual market on or after January 1, 2001, a health insurer shall offer the standard health benefit plan]~~. Except as may be necessary to coordinate with changes in federal law, the commissioner shall not alter, amend, or replace the standard health benefit plan more frequently than annually.~~[Initially, the standard health benefit plan shall be the standard high plan in effect on April 10, 1998.]~~

(2) ***If offered,*** the standard health benefit plan ***may***~~[shall]~~ be available in at least one (1) of these four (4) forms of coverage:

(a) A fee-for-service product type;

(b) A health maintenance organization type;

(c) A point-of-service type; and

(d) A preferred provider organization type.

(3) The standard health benefit plan shall be defined so that it meets the requirements of KRS 304.17B-021 for inclusion in calculating assessments and refunds under Kentucky Access.

(4) Any health insurer who ***offers the standard health benefit plan may***~~[elects to offer health insurance policies in the individual or small group markets in this state shall, as a condition of offering health benefit plans in this state after June 30, 1998,]~~ offer ~~[and issue]~~the standard health benefit plan in the individual or small group markets in each and every form of coverage that the health insurer offers to sell.

(5) Nothing in this section shall be construed:

(a) To require a health insurer to offer a standard health benefit plan in a form of coverage that the health insurer has not selected;

(b) To prohibit a health insurer from offering other health benefit plans in the individual or small group markets in addition to the standard health benefit plan; or

(c) To require that a standard health benefit plan have guaranteed issue, renewability, or pre-existing condition exclusion rights or provisions that are more generous to the applicant than the health insurer would be required to provide under KRS 304.17A-200, 304.17A-220, 304.17A.230, and 304.17A-240.

(6)~~[Insurance agents licensed under this chapter who present for sale any health benefit plan in the individual or small group markets to a prospective applicant shall also inform that person of the existence of the standard benefit plan in the same form of coverages offered by the same insurer.~~

~~(7) (a) A benefits comparison shall be delivered to a prospective applicant for any health insurance coverage in the individual or small group markets at the time of initial~~

~~solicitation through means that prominently direct the attention of the prospective applicant to the document and its purpose.~~

~~1. The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of a benefits comparison.~~

~~2. In the case of agent solicitations, an agent shall deliver the benefits comparison to the prospective applicant prior to the presentation of an application or enrollment form.~~

~~3. In the case of direct response solicitations, the benefits comparison shall be presented in conjunction with any application or enrollment form.~~

~~(b) The benefits comparison given to a prospective applicant shall include:~~

~~1. A description of the principal benefits and coverage provided in the standard health benefit plan offered under this section, and the health benefit policy being offered to the prospective applicant;~~

~~2. A statement of the principal exclusions, reductions, and limitations contained in the standard health benefit plan offered under this section, and the health benefit plan being offered to the prospective applicant; and~~

~~3. A chart providing a direct comparison of the insurer's premium rate for the standard health benefit plan offered under this section, and the health benefit policy being offered to the prospective applicant.~~

~~(c) At the time of the execution of an application for any health benefit plan, the prospective applicant shall sign a statement contained in or accompanying the application, which shall remain on file with the health insurer for five (5) years, indicating that the insured has been provided with and understands the benefits comparison required by this subsection.~~

~~(d) As used in this subsection and in subsection (6) of this section, the term "prospective applicant" refers only to a natural person who is a resident of the Commonwealth and who is purchasing health insurance coverage in the individual market providing benefits to that person, that person's spouse, or that person's children. It does not include an employer or representative of an employer who is considering health insurance coverage that would provide benefits to employees and their families.~~

~~(8)~~] All health benefit plans shall cover hospice care at least equal to the Medicare benefits.

(7)[~~(9)~~] All health benefit plans shall coordinate benefits with other health benefit plans in accordance with the guidelines for coordination of benefits prescribed by the commissioner as provided in KRS 304.18-085.

(8)[~~(10)~~] Every health insurer of any kind, nonprofit hospital, medical-surgical, dental and health service corporation, health maintenance organization, or provider-sponsored health delivery network that issues or delivers an insurance policy in this state that directs or gives any incentives to insureds to obtain health care services from certain health care providers shall not imply or otherwise represent that a health care provider is a participant in or an affiliate of an approved or selected provider network unless the health care provider has agreed in writing to the representation or there is a written contract between the health care provider and the insurer or an agreement by the provider to abide by the terms for participation established by the insurer. This requirement to have written contracts shall

apply whenever an insurer includes a health care provider as a part of a preferred provider network or otherwise selects, lists, or approves certain health care providers for use by the insurer's insureds. The obligation set forth in this section for an insurer to have written contracts with providers selected for use by the insurer shall not apply to emergency or out-of-area services.

(9)~~[(11)]~~ A self-insured plan may select any third party administrator licensed under KRS 304.9-052 to adjust or settle claims for persons covered under the self-insured plan.

(10)~~[(12)]~~ Any health insurer that fails to issue a premium rate quote to an individual within thirty (30) days of receiving a properly completed application request for the quote shall be required to issue coverage to that individual and shall not impose any pre-existing conditions exclusion on that individual with respect to the coverage. Each health insurer offering individual health insurance coverage in the individual market in the Commonwealth that refuses to issue a health benefit plan to an applicant or insured with a disclosed high-cost condition as specified in KRS 304.17B-001 or for any reason, shall provide the individual with a denial letter within twenty (20) working days of the request for coverage. The letter shall include the name and title of the person making the decision, a statement setting forth the basis for refusing to issue a policy, a description of Kentucky Access, and the telephone number for a contact person who can provide additional information about Kentucky Access.

(11)~~[(13)]~~ If a standard health benefit plan covers services that the plan's insureds lawfully obtain from health departments established under KRS Chapter 212, the health insurer shall pay the plan's established rate for those services to the health department.

(12)~~[(14)]~~ No individually insured person shall be required to replace an individual policy with group coverage on becoming eligible for group coverage that is not provided by an employer. In a situation where a person holding individual coverage is offered or becomes eligible for group coverage not provided by an employer, the person holding the individual coverage shall have the option of remaining individually insured, as the policyholder may decide. This shall apply in any such situation that may arise through an association, an affiliated group, the Kentucky state employee health insurance plan, or any other entity.

Section 5. KRS 304.17A-330 is amended to read as follows:

(1) All insurers authorized to write health insurance in this state and employer-organized associations that self-insure shall transmit at least annually by July 31 to the commissioner the following information, in a format prescribed by the commissioner, on their insurance experience in this state for the preceding calendar year:

(a)~~[(1)]~~ Total premium by product type and market segment;

(b)~~[(2)]~~ Total enrollment by product type and market segment;

(c)~~[(3)]~~ Total cost of medical claims filed by product type and market segment;

(d)~~[(4)]~~ Total amount of medical claims paid by the insurer and insured by product type and market segment;

(e)~~[(5)]~~ Total policies canceled by type and the aggregate reasons therefor; and

(f)~~[(6)]~~ List of total health and medical services paid for, grouped by types of services and costs:

1.~~[(a)]~~ Total cost per health and medical service per insured group:

a.~~[1.]~~Cost paid by insurer;

b.~~[2.]~~Cost paid by insured; and

2.~~[(b)]~~ Number of insureds who received each service.

(2) With the approval of the commissioner, the department may exempt insurers, employer-organized associations that self-insure, and health purchasing outlets from the data reporting requirements of this section if the total number of insureds is less than five hundred (500).

Section 6. KRS 304.17A-500 is amended to read as follows:

As used in KRS 304.17A-500 to 304.17A-590, unless the context requires otherwise:

(1) "Areas other than urban areas" means a classification code that does not meet the definition of urban area;

(2) "Contract holder" means an employer or organization that purchases a ***health benefit plan***~~[contract for services]~~;

(3) "Covered person" means a person on whose behalf an insurer offering the plan is obligated to pay benefits or provide services under the health insurance policy;

(4) "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part; or

(b) With respect to a pregnant woman who is having contractions:

1. A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or

2. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child;

(5) "Enrollee" means a person who is enrolled in a~~[managed health care]~~ plan ***offered by a health maintenance organization as defined in KRS 304.38-030(5)***;

(6) "Grievance" means a written complaint submitted by or on behalf of an enrollee;

(7) "Health insurance policy" means "health benefit plan" as defined in KRS 304.17A-005;

(8) "Insurer" has the meaning provided in KRS 304.17A-005;

(9) "Managed care plan" means a health insurance policy that integrates the financing and delivery of appropriate health care services to ***enrollees***~~[covered persons]~~ by arrangements with participating providers who are selected to participate on the basis of explicit standards to furnish a comprehensive set of health care services and financial incentives for ***enrollees***~~[covered persons]~~ to use the participating providers and procedures provided for in the plan;

(10) "Participating health care provider" means a health care provider that has entered into an agreement with an insurer to provide health care services~~[to an enrollee in its managed care plan]~~;

(11) "Quality assurance or improvement" means the ongoing evaluation by a managed care plan of the quality of health care services provided to its enrollees;

(12) "Record" means any written, printed, or electronically recorded material maintained by a provider in the course of providing health services to a patient concerning the patient and the services provided. "Record" also includes the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of health services to a patient or information otherwise acquired by the provider about a patient in confidence and in connection with the provision of health services to a patient;

(13) "Risk sharing arrangement" means any agreement that allows an insurer to share the financial risk of providing health care services to enrollees or insureds with another entity or provider where there is a chance of financial loss to the entity or provider as a result of the delivery of a service. A risk sharing arrangement shall not include a reinsurance contract with an accredited or admitted reinsurer;

(14) "Urban area" means a classification code whereby the zip code population density is greater than three thousand (3,000) persons per square mile; and

(15) "Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the plan. The system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures, and retrospective review.

Section 7. KRS 304.17A-520 is amended to read as follows:

(1) An enrollee shall have adequate choice among participating primary care providers in a managed care plan who are accessible and qualified.

(2) A managed care plan shall permit enrollees to choose their own primary care provider from a list of health care providers within the plan. This list shall be updated as health care providers are added or removed and shall include a sufficient number of primary care providers who are accepting new enrollees.

(3) Women shall be able to choose a qualified health care provider offered by a plan for the provision of covered care necessary to provide routine and preventive women's health care services.

(4) ***An insurer***~~[A managed care plan]~~ shall provide ***a covered person***~~[an enrollee]~~ with access to a consultation with a participating health care provider for a second opinion. Obtaining the second opinion shall not cost a covered person more than the covered person's normal copay ***or coinsurance amounts***.

Section 8. KRS 304.17A-527 is amended to read as follows:

(1) A managed care plan~~[as defined in KRS 304.17A-500]~~ shall file with the commissioner sample copies of any agreements it enters into with providers for the provision of health

care services. The commissioner shall promulgate administrative regulations prescribing the manner and form of the filings required. The agreements ~~[and contracts entered into or renewed after July 15, 2002,]~~shall include the following:

(a) A hold harmless clause that states that the provider may not, under any circumstance, including:

1. Nonpayment of moneys due the providers by the managed care plan,

2. Insolvency of the managed care plan, or

3. Breach of the agreement,

bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, dependent of subscriber, enrollee, or any persons acting on their behalf, for services provided in accordance with the provider agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for noncovered services;

(b) A continuity of care clause that states that if an agreement between the provider and the managed care plan is terminated for any reason, other than a quality of care issue or fraud, the provider shall continue to provide services and ***the plan shall continue to*** reimburse the provider in accordance with the agreement until the subscriber, dependent of the subscriber, or the enrollee is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater, and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy ***at the time the agreement is terminated***;

(c) A survivorship clause that states the hold harmless clause and continuity of care clause shall survive the termination of the agreement between the provider and the managed care plan;

(d) A clause stating that, upon request, the insurer shall provide the provider with specific fees for requested codes applicable to the compensation that the provider will receive under the contract with the insurer within thirty (30) days of the date of such request; and

(e) A clause requiring that if a provider enters into any subcontract agreement with another provider to provide their licensed health care services to the subscriber, dependent of the subscriber, or enrollee of a managed care plan where the subcontracted provider will bill the managed care plan or subscriber or enrollee directly for the subcontracted services, the subcontract agreement must meet all requirements of this subtitle and that all such subcontract agreements shall be filed with the commissioner in accordance with this subsection.

(2) An insurer ***that offers a health benefit plan*** that enters into any risk-sharing arrangement or subcontract agreement shall file a copy of the arrangement with the commissioner. The insurer shall also file the following information regarding the risk-sharing arrangement:

(a) The number of enrollees affected by the risk-sharing arrangement;

(b) The health care services to be provided to an enrollee under the risk-sharing arrangement;

(c) The nature of the financial risk to be shared between the insurer and entity or provider, including but not limited to the method of compensation;

(d) Any administrative functions delegated by the insurer to the entity or provider. The insurer shall describe a plan to ensure that the entity or provider will comply with KRS 304.17A-500 to 304.17A-590 in exercising any delegated administrative functions; and

(e) The insurer's oversight and compliance plan regarding the standards and method of review.

(3) Nothing in this section shall be construed as requiring an insurer to submit the actual financial information agreed to between the insurer and the entity or provider. The commissioner shall have access to a specific risk sharing arrangement with an entity or provider upon request to the insurer. Financial information obtained by the department shall be considered to be a trade secret and shall not be subject to KRS 61.872 to 61.884.

Section 9. KRS 304.17A-532 is amended to read as follows:

(1) As used in this section, "hospitalist" means a physician of record at a hospital for a patient of a participating physician and who may return the care of the patient to that physician at the end of the hospitalization.

(2) A contract between ***an insurer***~~[a managed care plan]~~ and a physician shall not require the mandatory use of a hospitalist.

Section 10. KRS 304.17A-550 is amended to read as follows:

(1) An insurer that offers a managed care plan shall offer a health benefit plan with out-of-network benefits to every contract holder***. The plan with out-of-network benefits shall***~~[that would]~~ allow a covered person to receive covered services from out-of-network health care providers without having to obtain a referral. The plan with out-of-network benefits may require that an enrollee pre-certify selected services and pay a higher deductible, copayment, coinsurance, excess charges and higher premium for the out-of-network benefit plan pursuant to limits established by administrative regulations promulgated by the department.

(2) ***If the contract holder elects the out-of-network offering required under subsection (1) of this section, the***~~[An]~~ insurer shall provide each enrollee~~[in a plan whose employer group elects the benefit plan with out-of-network benefits,]~~ with the opportunity at the time of enrollment and during the annual open enrollment period, to enroll in the out-of-network option. ***If the contract holder elects the out-of-network offering required under subsection (1) of this section,*** the insurer and ***the contract holder***~~[employer group]~~ shall provide written notice of the benefit plan with out-of-network benefits to each enrollee in a plan~~[whose employer group elects the benefit plan with out-of-network benefits]~~ and shall include in that notice a detailed explanation of the financial costs to be incurred by an enrollee who selects the plan.

(3) The requirement of this section shall not apply to an insurer contract which offers a managed care plan that provides health care services solely to Medicaid or Medicare recipients.

(4) Managed care plans currently licensed and doing business in Kentucky that do not yet offer benefit plans with out-of-network benefits must develop and offer those plans within three hundred sixty-five (365) days of April 10, 1998.

Section 11. KRS 304.17A-600 is amended to read as follows:

As used in KRS 304.17A-600 to 304.17A-633:

(1) (a) "Adverse determination" means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are:

1. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and

2. Benefit coverage is therefore denied, reduced, or terminated.

(b) "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan;

(2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of a covered person with respect to health care decisions;

(3) "Concurrent review" means utilization review conducted during a covered person's course of treatment or hospital stay;

(4) "Covered person" means a person covered under a health benefit plan;

(5) "External review" means a review that is conducted by an independent review entity which meets specified criteria as established in KRS 304.17A-623, 304.17A-625, and 304.17A-627;

(6) "Health benefit plan" means the document evidencing and setting forth the terms and conditions of coverage of any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network policy or certificate; a self-insured policy or certificate or a policy or certificate provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not include policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure, medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract, or coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or limited health service benefit plans; and for purposes of KRS 304.17A-600 to 304.17A-633 includes short-term coverage policies;

(7) "Independent review entity" means an individual or organization certified by the department to perform external reviews under KRS 304.17A-623, 304.17A-625, and 304.17A-627;

(8) "Insurer" means any of the following entities authorized to issue health benefit plans as defined in subsection (6) of this section: an insurance company, health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association; nonprofit hospital, medical-surgical, or health service corporation; or any other entity authorized to transact health insurance business in Kentucky;

(9) "Internal appeals process" means a formal process, as set forth in KRS 304.17A-617, established and maintained by the insurer, its designee, or agent whereby the covered person, an authorized person, or a provider may contest an adverse determination rendered by the insurer, its designee, or private review agent;

(10) "Nationally recognized accreditation organization" means a private nonprofit entity that sets national utilization review and internal appeal standards and conducts review of insurers, agents, or independent review entities for the purpose of accreditation or certification. Nationally recognized accreditation organizations shall include the National Committee for Quality Assurance (NCQA), the American Accreditation Health Care Commission (URAC), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or any other organization identified by the department;

(11) "Private review agent" or "agent" means a person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of any insurer or other person providing or administering health benefits to citizens of this Commonwealth. "Private review agent" or "agent" does not include an independent review entity which performs external review of adverse determinations;

(12) "Prospective review" means utilization review that is conducted prior to a hospital admission or a course of treatment;

(13) "Provider" shall have the same meaning as set forth in KRS 304.17A-005;

(14) "Qualified personnel" means licensed physician, registered nurse, licensed practical nurse, medical records technician, or other licensed medical personnel who through training and experience shall render consistent decisions based on the review criteria;

(15) "Registration" means an authorization issued by the department to an insurer or a private review agent to conduct utilization review;

(16) "Retrospective review" means utilization review that is conducted after health care services have been provided to a covered person. "Retrospective review" does not include the review of a claim that is limited to an evaluation of reimbursement levels, or adjudication of payment;

(17) ***(a) "Urgent care" means health care or treatment with respect to which the application of the time periods for making nonurgent determination:***

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

2. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; and

(b) "Urgent care" shall include all requests for hospitalization and outpatient surgery;

(18) "Utilization review" means a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a covered person for purposes of determining the availability of payment. Areas of review include concurrent, prospective, and retrospective review; and

(19)~~[(18)]~~ "Utilization review plan" means a description of the procedures governing utilization review activities performed by an insurer or a private review agent.

Section 12. KRS 304.17A-607 is amended to read as follows:

(1) An insurer or private review agent shall not provide or perform utilization reviews without being registered with the department. A registered insurer or private review agent shall:

(a) Have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported by licensed physicians with access to consultation with other appropriate physicians to carry out its utilization review activities;

(b) Ensure that only licensed physicians shall:

1. Make a utilization review decision to deny, reduce, limit, or terminate a health care benefit or to deny, or reduce payment for a health care service because that service is not medically necessary, experimental, or investigational except in the case of a health care service rendered by a chiropractor or optometrist where the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky; and

2. Supervise qualified personnel conducting case reviews;

(c) Have available the services of sufficient numbers of practicing physicians in appropriate specialty areas to assure the adequate review of medical and surgical specialty and subspecialty cases;

(d) Not disclose or publish individual medical records or any other confidential medical information in the performance of utilization review activities except as provided in the Health Insurance Portability and Accountability Act, Subtitle F, secs. 261 to 264 and 45 C.F.R. secs. 160 to 164 and other applicable laws and administrative regulations;

(e) Provide a toll free telephone line for covered persons, authorized persons, and providers to contact the insurer or private review agent and be accessible to covered persons, authorized persons, and providers for forty (40) hours a week during normal business hours in this state;

(f) Where an insurer, its agent, or private review agent provides or performs utilization review, be available to conduct utilization review during normal business hours and extended hours in this state on Monday and Friday through 6:00 p.m., including federal holidays;

(g) Provide decisions to covered persons, authorized persons, and all providers on appeals of adverse determinations and coverage denials of the insurer or private review agent, in accordance with this section and administrative regulations promulgated in accordance with KRS 304.17A-609;

(h) ***Except for retrospective review of an emergency admission where the covered person remains hospitalized at the time the review request is made, which shall be considered a concurrent review,*** provide a utilization review decision ***relating to urgent and nonurgent care in accordance with 29 C.F.R. Part 2560, including the timeframes and***~~[within the timeframes listed in this paragraph that will be followed by]~~ written notice of the decision~~[within one (1) business day of the date the decision is rendered]~~. A written notice in electronic format, including e-mail or facsimile, may suffice for this purpose where the covered person, authorized person, or provider has agreed in advance in writing to receive such notices electronically and shall include the required elements of subsection (j) of this section~~[:~~

~~1. Within twenty-four (24) hours of a request for:~~

~~a. Preadmission review of a hospital admission, unless additional information is needed;~~

~~b. Preauthorization of treatment when the covered person is already hospitalized; or~~

~~c. Retrospective review of an emergency hospital admission;~~

~~2. Within two (2) business days of receipt of a request for preauthorization for a treatment, procedure, drug, or device, unless there is a documented need for additional information; and~~

~~3. Within twenty (20) business days of the receipt of requested medical information when the insurer or private review agent has initiated a retrospective review]~~;

(i) Provide a utilization review decision within twenty-four (24) hours of receipt of a request for review of a covered person's continued hospital stay and prior to the time when a previous authorization for hospital care will expire;

(j) Provide written notice of review decisions to the covered person, authorized person, and providers. An insurer or agent that denies coverage or reduces payment for a treatment, procedure, drug ***that requires prior approval***, or device shall include in the written notice:

1. A statement of the specific medical and scientific reasons for denial or reduction of payment ***or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available***;

2. The state of licensure, medical license number, and the title of the reviewer making the decision;

3. ***Except for retrospective review,*** a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and

4. Instructions for initiating or complying with the insurer's internal appeal procedure, as set forth in KRS 304.17A-617, stating, at a minimum, whether the appeal shall be in writing, and any specific filing procedures, including any applicable time limitations or schedules, and the position and phone number of a contact person who can provide additional information;

(k) Afford participating physicians an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer and afford other participating providers an opportunity to review and comment on all of the

insurer's protocols that are within the provider's legally authorized scope of practice; and

(l) Comply with its own policies and procedures on file with the department or, if accredited or certified by a nationally recognized accrediting entity, comply with the utilization review standards of that accrediting entity where they are comparable and do not conflict with state law.

(2) The insurer's failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be an adverse determination by the insurer for the purpose of initiating an internal appeal as set forth in KRS 304.17A-617. This provision shall not apply where the failure to make the determination or provide the notice results from circumstances which are documented to be beyond the insurer's control.

(3) An insurer or private review agent shall submit a copy of any changes to its utilization review policies or procedures to the department. No change to policies and procedures shall be effective or used until after it has been filed with and approved by the commissioner.

(4) A private review agent shall provide to the department the names of the entities for which the private review agent is performing utilization review in this state. Notice shall be provided within thirty (30) days of any change.

Section 13. KRS 304.17A-617 is amended to read as follows:

(1) Every insurer shall have an internal appeal process to be utilized by the insurer or its designee, consistent with this section and KRS 304.17A-619 and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g). An insurer shall disclose the availability of the internal process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial which meets the requirements set forth in KRS 304.17A-607(1)(j). For purposes of this section "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan. Where a coverage denial is involved, in addition to stating the reason for the coverage denial, the required notice shall contain instructions for filing a request for internal appeal.

(2) The internal appeals process may be initiated by the covered person, an authorized person, or a provider acting on behalf of the covered person. The internal appeals process shall include adequate and reasonable procedures for review and resolution of appeals concerning adverse determinations made under utilization review and of coverage denials, including procedures for reviewing appeals from covered persons whose medical conditions require expedited review. At a minimum, these procedures shall include the following:

(a) Insurers or their designees shall provide decisions to covered persons, authorized persons, and providers on internal appeals of adverse determinations or coverage denials within thirty (30) days of receipt of the request for internal appeal;

(b) Insurers or their designees shall render a decision not later than three (3) business days after receipt of the request for an expedited appeal of either an adverse determination or a coverage denial. An expedited appeal is deemed necessary when a covered person is hospitalized or, in the opinion of the treating provider, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:

1. Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or the unborn child in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of a bodily organ or part;

(c) Internal appeal of an adverse determination shall only be conducted by a licensed physician who did not participate in the initial review and denial. However, in the case of a review involving a medical or surgical specialty or subspecialty, the insurer or agent shall, upon request by a covered person, authorized person, or provider, utilize a board eligible or certified physician in the appropriate specialty or subspecialty area to conduct the internal appeal;

(d) Those portions of the medical record that are relevant to the internal appeal, if authorized by the covered person and in accordance with state or federal law, shall be considered and providers given the opportunity to present additional information;

(e) In addition to any previous notice required under KRS 304.17A-607(1)(j), and to facilitate expeditious handling of a request for external review of an adverse determination or a coverage denial, an insurer or agent that denies, limits, reduces, or terminates coverage for a treatment, procedure, drug, or device for a covered person shall provide the covered person, authorized person, or provider acting on behalf of the covered person with an internal appeal determination letter that shall include:

1. A statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;

2. The state of licensure, medical license number, and the title of the person making the decision;

3. ***Except for retrospective review,*** a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and

4. Instructions for initiating an external review of an adverse determination, or filing a request for review with the department if a coverage denial is upheld by the insurer on internal appeal.

(3) The department shall establish and maintain a system for receiving and reviewing requests for review of coverage denials from covered persons, authorized persons, and providers. For purposes of this subsection "coverage denials" shall not include an adverse determination as defined in KRS 304.17A-600 or subsequent denials arising from an adverse determination.

(a) On receipt of a written request for review of a coverage denial from a covered person, authorized person, or provider, the department shall notify the insurer which issued the denial of the request for review and shall call for the insurer to respond to the department regarding the request for review within five (5) days of receipt of notice to the insurer;

(b) Within five (5) days of receiving the notice of the request for review from the department, the insurer shall provide to the department the following information:

1. Confirmation as to whether the person who received or sought the health service for which coverage was denied was a covered person under a health benefit plan issued by the insurer on the date the service was sought or denied;

2. Confirmation as to whether the covered person, authorized person, or provider has exhausted his or her rights under the insurer's appeal process under this section; and

3. The reason for the coverage denial, including the specific limitation or exclusion of the health benefit plan demonstrating that coverage is not available;

(c) In addition to the information described in paragraph (b) of this subsection, the insurer and the covered person, authorized person, or provider shall provide to the department any information requested by the department that is germane to its review;

(d) On the receipt of the information described in paragraphs (b) and (c) of this subsection, unless the department is not able to do so because making a determination requires resolution of a medical issue, it shall determine whether the service, treatment, drug, or device is specifically limited or excluded under the terms of the covered person's health benefit plan. If the department determines that the treatment, service, drug, or device is not specifically limited or excluded, it shall so notify the insurer, and the insurer shall either cover the service, or afford the covered person an opportunity for external review under KRS 304.17A-621, 304.17A-623, and 304.17A-625, where the conditions precedent to the review are present. If the department notifies the insurer that the treatment, service, drug, or device is specifically limited or excluded in the health benefit plan, the insurer is not required to cover the service or afford the covered person an external review;

(e) An insurer shall be required to cover the treatment, service, drug, or device that was denied or provide notification of the right to external review in accordance with paragraph (d) of this subsection whether the covered person has disenrolled or remains enrolled with the insurer;

(f) If the covered person has disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was denied for a period not to exceed thirty (30) days, or provide the covered person the opportunity for external review.

Section 14. KRS 304.17A-623 is amended to read as follows:

(1) Every insurer shall have an external review process to be utilized by the insurer or its designee, consistent with this section and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g). An insurer, its designee, or agent shall disclose the availability of the external review process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial as set forth in KRS 304.17A-607(1)(j) and in the denial letter required in KRS 304.17A-617(1) and (2)(e). For purposes of this section "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan.

(2) A covered person, an authorized person, or a provider acting on behalf of and with the consent of the covered person, may request an external review of an adverse determination rendered by an insurer, its designee, or agent.

(3) The insurer shall provide for an external review of an adverse determination if the following criteria are met:

(a) The insurer, its designee, or agent has rendered an adverse determination;

(b) The covered person has completed the insurer's internal appeal process, or the insurer has failed to make a timely determination or notification as set forth in KRS 304.17A-619(2). The insurer and the covered person may however, jointly agree to waive the internal appeal requirement;

(c) The covered person was enrolled in the health benefit plan on the date of service or, if a prospective denial, the covered person was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed service was requested; and

(d) The entire course of treatment or service will cost the covered person at least one hundred dollars ($100) if the covered person had no insurance.

(4) The covered person, an authorized person, or a provider with consent of the covered person shall submit a request for external review to the insurer within sixty (60) days, except as set forth in KRS 304.17A-619(1), of receiving notice that an adverse determination has been timely rendered under the insurer's internal appeal process. As part of the request, the covered person shall provide to the insurer or its designee written consent authorizing the independent review entity to obtain all necessary medical records from both the insurer and any provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

(5) The covered person shall be assessed a one (1) time filing fee of twenty-five dollars ($25) to be paid to the independent review entity and which may be waived if the independent review entity determines that the fee creates a financial hardship on the covered person. The fee shall be refunded if the independent review entity finds in favor of the covered person.

(6) A covered person shall not be afforded an external review of an adverse determination if:

(a) The subject of the covered person's adverse determination has previously gone through the external review process and the independent review entity found in favor of the insurer; and

(b) No relevant new clinical information has been submitted to the insurer since the independent review entity found in favor of the insurer.

(7) The department shall establish a system for each insurer to be assigned an independent review entity for external reviews. The system established by the department shall be prospective and shall require insurers to utilize independent review entities on a rotating basis so that an insurer does not have the same independent review entity for two (2) consecutive external reviews. The department shall contract with no less than two (2) independent review entities.

(8) (a) If a dispute arises between an insurer and a covered person regarding the covered person's right to an external review, the covered person may file a complaint with the department. Within five (5) days of receipt of the complaint, the department shall render a decision and may direct the insurer to submit the dispute to an independent review entity for an external review if it finds:

1. The dispute involves denial of coverage based on medical necessity or the service being experimental or investigational; and

2. All of the requirements of subsection (3) of this section have been met.

(b) The complaint process established in this section shall be separate and distinct from, and shall in no way limit other grievance or complaint processes available to consumers under other provisions of the KRS or duly promulgated administrative regulations. This complaint process shall not limit, alter, or supplant the mechanisms for appealing coverage denials established in KRS 304.17A-617.

(9) The external review process shall be confidential and shall not be subject to KRS 61.805 to 61.850 and KRS 61.870 to 61.884.

(10) External reviews shall be conducted in an expedited manner by the independent review entity if the covered person is hospitalized, or if, in the opinion of the treating provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

(a) Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or her unborn child in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of a bodily organ or part.

(11) Requests for expedited external review, shall be forwarded by the insurer to the independent review entity within twenty-four (24) hours of receipt by the insurer.

(12) For expedited external review, a determination shall be made by the independent review entity within twenty-four (24) hours from the receipt of all information required from the insurer. An extension of up to twenty-four (24) hours may be allowed if the covered person and the insurer or its designee agree. The insurer or its designee shall provide notice to the independent review entity and to the covered person, by same-day communication, that the adverse determination has been assigned to an independent review entity for expedited review.

(13) External reviews which are not expedited shall be conducted by the independent review entity and a determination made within twenty-one (21) calendar days ***from the receipt of all information required from the insurer*** ~~[of receipt of the request for external review]~~. An extension of up to fourteen (14) calendar days may be allowed if the covered person and the insurer are in agreement.

Section 15. KRS 304.17A-627 is amended to read as follows:

(1) To be certified as an independent review entity under this chapter, an organization shall submit to the department an application on a form required by the department. The application shall include the following:

(a) The name of each stockholder or owner of more than five percent (5%) of any stock or options for an applicant;

(b) The name of any holder of bonds or notes of the applicant that exceeds one hundred thousand dollars ($100,000);

(c) The name and type of business of each corporation or other organization that the applicant controls or with which it is affiliated and the nature and extent of the affiliation or control;

(d) The name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under paragraph (c) of this subsection and a description

of any relationship the named individual has with an insurer as defined in KRS 304.17A-600 or a provider of health care services;

(e) The percentage of the applicant's revenues that are anticipated to be derived from independent reviews;

(f) A description of the minimum qualifications employed by the independent review entity to select health care professionals to perform external review, their areas of expertise, and the medical credentials of the health care professionals currently available to perform external reviews; and

(g) The procedures to be used by the independent review entity in making review determinations; and

(2) If at any time there is a material change in the information included in the application, provided for in subsection (1) of this section, the independent review entity shall submit updated information to the department.

(3)~~[The independent review entity shall annually submit to the department the information required by subsection (1) of this section in a form acceptable to the department.~~

~~(4)]~~ An independent review entity shall not be a subsidiary of, or in any way affiliated with, or owned, or controlled by an insurer or a trade or professional association of payors.

(4)~~[(5)]~~ An independent review entity shall not be a subsidiary of, or in any way affiliated with, or owned, or controlled by a trade or professional association of providers.

(5)~~[(6)]~~ Health care professionals who are acting as reviewers for the independent review entity shall hold in good standing a nonrestricted license in a state of the United States.

(6)~~[(7)]~~ Health care professionals who are acting as reviewers for the independent review entity shall hold a current certification by a recognized American medical specialty board or other recognized health care professional boards in the area appropriate to the subject of the review, be a specialist in the treatment of the covered person's medical condition under review, and have actual clinical experience in that medical condition.

(7)~~[(8)]~~ The independent review entity shall have a quality assurance mechanism to ensure the timeliness and quality of the review, the qualifications and independence of the physician reviewer, and the confidentiality of medical records and review material.

(8)~~[(9)]~~ Neither the independent review entity nor any reviewers of the entity, shall have any material, professional, familial, or financial conflict of interest with any of the following:

(a) The insurer involved in the review;

(b) Any officer, director, or management employee of the insurer;

(c) The provider proposing the service or treatment or any associated independent practice association;

(d) The institution at which the service or treatment would be provided;

(e) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the covered person whose treatment is under review; or

(f) The covered person.

(9)~~[(10)]~~ As used in this section, "conflict of interest" shall not be interpreted to include:

(a) A contract under which an academic medical center or other similar medical center provides health care services to covered persons, except for academic medical centers that may provide the service under review;

(b) Provider affiliations which are limited to staff privileges; or

(c) A specialist reviewer's relationship with an insurer as a contracting health care provider, except for a specialist reviewer proposing to provide the service under review.

(10) ~~[(11)]~~ On an annual basis, the independent review entity shall report to the department the following information:

(a) The number of independent review decisions in favor of covered persons;

(b) The number of independent review decisions in favor of insurers;

(c) The average turnaround time for an independent review decision;

(d) The number of cases in which the independent review entity did not reach a decision in the time specified in statute or administrative regulation; and

(e) The reasons for any delay.

Section 16. KRS 304.17A-700 is amended to read as follows:

As used in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123.

(1) "Adjudicate" means an insurer pays, contests, or denies a clean claim;

(2) "Claims payment time frame" means the time period prescribed under KRS 304.17A-702 following receipt of a clean claim from a provider at the address published by the insurer, whether it is the address of the insurer or a delegated claims processor, within which an insurer is required to pay, contest, or deny a health care claim;

(3) "Clean claim" means a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form.

(a) A clean claim from an institutional provider shall consist of:

1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;

2. Entries stated as mandatory by the NUBC; and

3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.

(b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.

(c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.

(d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs;

(4) "Commissioner" means the commissioner of the Department of Insurance;

(5) "Covered person" means a person on whose behalf an insurer offering a health benefit plan is obligated to pay benefits or provide services;

(6) "Department" means the Department of Insurance;

(7) "Electronic" or "electronically" means electronic mail, computerized files, communications, or transmittals by way of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities;

(8) "Health benefit plan" has the same meaning as provided in KRS 304.17A-005;

(9) "Health care provider" or "provider" means a provider licensed in Kentucky as defined in KRS 304.17A-005 and, for the purposes of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 only, shall include physical therapists licensed under KRS Chapter 327, psychologists licensed under KRS Chapter 319, and social workers licensed under KRS Chapter 335. Nothing contained in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 shall be construed to include physical therapists, psychologists, and social workers as a health care provider or provider under KRS 304.17A-005;

(10) "Health claim attachments" means medical information from a covered person's medical record required by the insurer containing medical information relating to the diagnosis, the treatment, or services rendered to the covered person and as may be required pursuant to KRS 304.17A-720;

(11) "Institutional provider" means a health care facility licensed under KRS Chapter 216B;

(12) "Insurer" has the same meaning provided in KRS 304.17A-005;

(13) "Kentucky Uniform Billing Committee (KUBC)" means the committee of health care providers, governmental payors, and commercial insurers established as a local arm of NUBC to implement the bill requirements of the NUBC and to prescribe any additional billing requirements unique to Kentucky insurers;

(14) "National Uniform Billing Committee (NUBC)" means the national committee of health care providers, governmental payors, and commercial insurers that develops the national uniform billing requirements for institutional providers as referenced in accordance with the Federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. Chapter 6A, Subchapter XXV, sec. 300gg et seq.;

(15) "Retrospective review" means utilization review that is conducted after health care services have been provided to a covered person; and

(16) "Utilization review" has the same meaning as provided in KRS 304.17A-600***(18)*** ~~[(17)]~~.

Section 17. The following KRS section is repealed:

304.17A-533 Prohibition against contract requiring mandatory use of hospitalist.

Section 18. Section 1 of this Act takes effect January 1, 2005.

Approved April 2, 2004